Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PEDRO NOSNIK, MD PA

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-11-3021-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting full payment for this claim…The posted denial states 'CPT 95955-59-TC no covered by Medicare, see attached EEG notice from Trailblazer, and CPT 95934-TC-76 included in another procedure, I do not find this included with another procedure we used the '76' modifier on the 2nd unit.' Please review again and notice the intra operative monitoring and billing is for the compensable injury."

Amount in Dispute: $170.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2010	CPT Code 95955-59-TC Electroencephalogram, EEG	$134.57	$131.29
	CPT Code 95934-TC-76 H-reflex, Amplitude and Latency Study, Record Gastrocnemus/Soleus Muscle.	$35.66	$0.00
TOTAL		$170.73	$131.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X212-This procedure is included in another procedure performed on this date.

- B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 11, 2011. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Is the value of CPT code 95955-59-TC included in the value of another procedure billed on the disputed date?
2. Is the value of CPT code 95934-76-TC included in the value of another procedure billed on the disputed date?
3. Is the requestor entitled to additional reimbursement for code 95955-59-TC?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 95955-59-TC based upon reason code "B291."

   Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   On the disputed dates of service, the requestor billed CPT codes 95920-59-TC, 95925-TC, 95926-TC, 95936-TC, 95861-TC, 95955-59-TC, 95937-TC, 95934-TC, 95934-76-TC, A4556 and A4558.

   According to the CCI edits, CPT code 95955 is not a component of any of the other codes billed on the disputed date; therefore, the respondent's denial of payment based upon B291 is not supported. Reimbursement in accordance with the Division's fee guideline is recommended.

2. According to the submitted explanation of benefits, the respondent paid $34.79 for CPT Code 95934-TC and $0.00 for 95934-76-TC based upon reason code "X212."

   CPT Code 95934 is defined as "H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle." The requestor appended modifier "76-Repeat procedure by same physician" to the second 95934 code. A review of the submitted reports does not support billing a second study for the same operative session. As a result, reimbursement is not recommended.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   Review of Box 32 on the CMS-1500 the services were rendered in Plano, Texas; therefore, the Medicare participating amount is based upon the locality of "Rest of Texas".

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The Medicare conversion factor is 36.8729.

The Medicare participating amount for code 95955-TC is $89.12.

Using the above formula, the MAR is $131.29. The respondent paid $0.00. As a result, the requestor is due an additional reimbursement of $131.29.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $131.29.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $131.29 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		06/18/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.